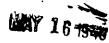
DEPARTMENT OF COMMERCE STATE BOARD OF HEALTH OF MISSOURI No. 2 BURBAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH 1-2-43 State File No. 5-17-39 LED NOV 9
Registration District No.... Registrar's No._ // 2 3 I X35697 Primary Registration District No. 1000 1. PLACE OF DEATH: 2. USUAL RESIDENCE OF DECEASED: (a) County Buchanan, (b) City or town Saint Joseph, (a) State Missouri, (b) County Buchanan PERMANENT RECORD (c) City or town Saint Joseph. (If outside city or town limits, write "RURAL" and name of township) (c) Name of hospital or institution: 619 Bon Ton Street, Missouri Methodist Hospital (If not in hospital or institution, write street number or location) (If rural, give location) (d) Length of stay: In hospital or institution 2 days. NO . (Yes qr No) (e) Citizen of foreign country?...... In this community 43 years. years, months or days) If yes, name country. MEDICAL CERTIFICATION 3. (a) PRINT FUGENE Cooper. 20. DATE OF DEATH: Month Octoberder 12th. 3. (b) If veteran. 3. (c) Social Security No.491-09-0535 name war..... 21. I hereby certify that I attended the deceased from...... 5., Color or 6. (a) Single, widowed, married divorced Married //mcc White and that death occurred on the date and hour stated above. Stella Cooper. 7. Birth date of deceased July 26, (Month) 8. AGE: Years Months Days If less than one day UNFADING 68 9. Birthplace Colto-Neck, New Jersey, (City, town, or county) (State or foreign country) Other conditions. 10. Usual occupation ACCOUNTANT. (Include pregnancy within 3 months of death) 11. Industry or business...... PHYSICIAN Major findings: Cooper. 12 Name James E. Of operations..... Underline New Jersey. Unknown. the cause to which death (City, town, or county)
14. Maiden name Saran Haight (State or foreign country) Of autopsy..... charged sta-New Jersey, 2 tistically. Unknown. 15. Birthplace..... 22. If death was due to external causes, fill in the following: (State or foreign country) (City, town, or county) (a) Accident, suicide, or homicide (specify) 16. (a) Informant.... 619 Bon Ton Street. (b) Date of occurrence (b) Address Burial (b) Date thereof 10/16/43 (Burial, cremation, or removal) (c) Where did injury occur?..... (Month) (Day) (Year) St. Jo. Mem. Park Cem. (a) Signature of Juneral director Bere 319 So.10th. Street (b) Address..... Date signed (Licensed Embalmer's Statement on Reverse Side



STATEMENT	BI MCERSED EMBALMER
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by	
	, Registered Apprentice No
working under my personal supervision.	Signed Fine Thomas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

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